**STATE OF MICHIGAN**

**DEPARTMENT OF LABOR & ECONOMIC GROWTH**

**OFFICE OF FINANCIAL AND INSURANCE REGULATION**

**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**
**Petitioner** **File No. 100310-001-SF**

**v**

**Blue Cross Blue Shield of Michigan**
**Respondent**
_____/

**Issued and entered**
**this 22nd day of December 2008**
**by Ken Ross**
**Commissioner**

**ORDER**

**I**
**PROCEDURAL BACKGROUND**

On September 22, 2008, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on September 29, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received Blue Cross Blue Shield's response on October 8, 2008.

The Petitioner is enrolled for health coverage through the City of XXXXX, a self-funded local government group. BCBSM administers the plan. The issue in this external review can be decided

by a contractual analysis. The contract here is BCBSM's Community Blue Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

## II
## FACTUAL BACKGROUND

The Petitioner was an inpatient at the XXXXX Hospital from August 24 to August 27, 2007. While in the hospital, she received care from a physician who was neither a PPO panel provider nor a participating provider with BCBSM. This doctor charged $724.00 for the care and BCBSM approved $394.28. BCBSM applied a $250.00 nonpanel deductible and a 20% nonpanel copayment to its approved amount and paid $115.43 to the Petitioner.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on July 16, 2008, and issued a final adverse determination dated July 22, 2008.

## III
## ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's care provided by a nonpanel physician from August 24 to August 27, 2007?

## IV
## ANALYSIS

Petitioner's Argument

The Petitioner was seen by several doctors during her stay at the XXXXX Hospital, including one nonpanel doctor. The Petitioner assumed, since she had informed the hospital that she had BCBSM insurance, that all the doctors who would see her would be in-network. She argues that she should have been informed and given a choice between a panel and a nonpanel doctor. Because BCBSM failed to make its full payment for the care provided by the nonpanel physician, the Petitioner paid $375.92 to the hospital to avoid calls from debt collectors.

The Petitioner wants BCBSM to reimburse her for the amount she had to pay for the

nonpanel doctor.

BCBSM's Argument

BCBSM says that page 4.2 of the certificate clearly states that BCBSM pays its "approved amount" for covered services. The approved amount is defined as the lesser of the provider's charge or BCBSM's maximum payment level for the service. The certificate does not guarantee that charges will be paid in full. Moreover, since the nonpanel physician in this case does not participate with BCBSM, the physician is not required to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between the charge and BCBSM's approved amount.

BCBSM points to two provisions in the certificate. On page 2.1 is says:

> Nonpanel Providers
>
> You are required to pay the following deductible each calendar year for covered services provided by nonpanel providers:
>
> - $250 for one member

On page 2.3 it says:

> Nonpanel Providers
>
> You are required to pay the following copayments for covered services provided by nonpanel providers:
>
> * * *
>
> - 20 percent of the approved amount for most other services

BCBSM says that because the Petitioner did not receive a written referral to the nonpanel physician from a PPO panel physician (in which case the deductible would have been waived), the nonpanel physician's services are subject to both a $250 deductible and a 20% copayment.

The amounts charged by the doctor and the amounts paid by BCBSM are listed in the following chart:

| Date of Service | Amount Charged by Nonpanel Physician | BCBSM's Approved Amount | Applied to Deductible | Petitioner's Copayment | BCBSM's Payment |
|---|---|---|---|---|---|
| 8/24/07 | $378.00 | $199.92 | $199.92 | $0.00 | $0.00 |
| 8/26/07 | $197.00 | $103.65 | $50.08 | $10.71 | $42.86 |
| 8/27/07 | $149.00 | $90.71 | $0.00 | $18.14 | $72.57 |
| Totals | $724.00 | $394.28 | $250.00 | $28.85 | $115.43 |

BCBSM contends that it has paid the proper amount and is not required to pay more.

Commissioner's Review

Under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from PPO panel members or from other providers who participate with BCBSM. One of the doctors that provided care while the Petitioner was in the hospital was neither a PPO panel provider nor a participating provider. The certificate warns enrollees (page 4.29):

> If the nonpanel provider is nonparticipating, you will need to pay most of the charges yourself. Your bill could be substantial. * * *
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate describes how benefits are paid when services are received from a nonpanel and nonparticipating provider. First, BCBSM only pays its "approved amount" for covered services -- it does not guarantee that the provider's charge will be paid in full. "Approved amount" is defined in the certificate as "the BCBSM maximum payment level or the provider's charge for the covered service, whichever is lower." Second, because the doctor was not part of BCBSM's PPO panel, the approved amount for his services is subject to a $250.00 deductible and then a 20% copayment.

The Commissioner understands why the Petitioner is upset. Sometimes, as happened here, a provider at a facility will not participate with BCBSM or be part of a BCBSM PPO panel. Furthermore, it is not always feasible while in the hospital to determine the status of every provider. Nevertheless, it is the status of the provider that determines how BCBSM processes claims and

makes it payment under the terms of the certificate.

The Commissioner finds that the amount BCBSM paid for the Petitioner's care at the XXXXX Hospital in August 2007 is consistent with the provisions of her certificate and that BCBSM is not required to pay any additional amount.

## V
## ORDER

BCBSM's final adverse determination of July 22, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's care at the XXXXX Hospital.

This is a final decision of an administrative agency. A person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.